MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07435

Reg. Diat. No. 351

1. PLACE OF DEATH:

County: Worcester

City or town: Dr Newark

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Newark

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Margie Ella Adkins

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Gordon Adkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 24, 1869

8. AGE:

Years	Months	Days	If less than one day
76	8	20	hrs. ..... min.

9. Birthplace: Cedartown, Georgia (except Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER — 12. Name: James L. Fraden.

13. Birthplace: Maryland.

MOTHER — 14. Maiden name: Nicey E. Richardson

15. Birthplace: Md.

18. Informant: Mrs. George Hill

Address: Newark, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/15/46 (month) (day) (year)

Cemetery or crematory: Bowen.

Location: Newark Md

18. Funeral director: Anna A. Burbage

Address: Berlin Md.

19. 7/17/46 (Date rec'd by registrar) LeRoy Smith. Registrar

Verbal burial permit 7/15/46

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-14-46, 19..., at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1-46, 19..., to 7-14-46, 19...; and that I last saw h.. alive on 7-14-46, 19...

Immediate cause of death	DURATION
Cerebral apoplexy	
Due to: Hypertension	
Due to: ✓	
Other conditions: ✓	

(Include pregnancy within 3 months of death)

Major findings of operations: None ✓

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Clifford E. Lokert M. D.

Address: Berlin Md Date signed: 7/17/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07436

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Showell (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Week

Hospital, institution, or street address where death occurred: 1 Week

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Parsonsburg (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary E. Adkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Jacob M. Adkins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 26, 1864

8. AGE: Years	Months	Days	If less than one day
81	11	2	hrs. min.

9. Birthplace: Wicomico Co., Md (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER 12. Name: John L. Morris

FATHER 13. Birthplace: Wicomico Co. Md

MOTHER 14. Maiden name: Hannah Shockley

MOTHER 15. Birthplace: Wicomico Co. Md

16. Informant: Mr. Paul Adkins

Address: Salisbury, Md R. D. 3

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 / 31 / 46 (month) (day) (year)

Cemetery or crematory: Forest Grove Cemetery

Location: Parsonsburg, Md

16. Funeral director: The Hill & Johnson Co

Address: Salisbury, Md

19. 7-31-46 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1946 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 22 1946 to July 28 1946 and that I last saw h[illegible] alive on July 28 1946

Immediate cause of death	DURATION
Cerebral thrombosis	4 wks
Due to: Carcinoma of throat	4 mo.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert S. Long M. D. or other

Address: Frankford Del Date signed: 7-29-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07437

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Laura Armstrong

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: Years: 68 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Pocomoke, Worcester, Md. (Town, county, and state)
10. Usual occupation: House work
11. Industry or business
FATHER — 12. Name: Jessie Armstrong
13. Birthplace: Maryland
MOTHER — 14. Maiden name: Emma Aydelotte
15. Birthplace: Maryland
16. Informant: Joseph Armstrong
Address: Pocomoke City Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 28-1946 (month) (day) (year)
Cemetery or crematory: Hall Hill Cemetery
Location: Rural Pocomoke
18. Funeral director: Henry H. Watson
Address: Pocomoke City Md
19. July 27 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1946 8:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20 1946 to July 24 1946
and that I last saw h— alive on July 24 1946
Immediate cause of death: Myocardial degeneration

	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: [illegible] Date signed: 7-26-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

07438

CERTIFICATE OF DEATH

Reg. Diat. No. 357

1. PLACE OF DEATH:

County Worcester

City or town Middletown Rural #1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Middletown Rural #1
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Daniel M. Ball

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Hattie E. Ball

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Dec. 9 1885

8. AGE: Years 60 | Months 7 | Days 21 | If less than one day ... hrs. ... min.

9. Birthplace Newtown Accomac Virginia
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Edward Thomas Ball

13. Birthplace Virginia

MOTHER 14. Maiden name Bernettie A. Davis

15. Birthplace Virginia

16. Informant Mrs. George H. Truitt

Address Snow Hill, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1946 (month) (day) (year)

Cemetery or crematory Nelson

Location Allemonde Lodge, Md. Rural

18. Funeral director Hearne & Dennis

Address Snow Hill Md

19. 7/31 1946 (Date rec'd by registrar) L. Leroy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1946, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1945, to July 29 1946 and that I last saw h... alive on July 29 1946

Immediate cause of death	DURATION
Interstitial Pneumonitis	4 days
Due to Diabetes Mellitus	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Cohen M.D.
M. D. or other

Address Snow Hill Md Date signed 7/30/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:
County ..... Worcester
City or town ..... Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... Maryland ..... County ..... Balto
City or town ..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. ..... 7 W. Preston St
(If rural, give LOCATION)
2.(a) If veteran, name war ..... ✓

3.(a) FULL NAME John A. Barber Jr. | **3.(b) Social Security Number** 217-16-1648

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife .....
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) April 11 - 1904

8. AGE: Years	Months	Days	If less than one day
42	3	16	..... hrs. ..... min.

9. Birthplace ..... maryland (Town, county, and state)
10. Usual occupation ..... Contracting
11. Industry or business .....

FATHER
12. Name ..... John A Barber
13. Birthplace ..... maryland

MOTHER
14. Maiden name ..... Mary Gittings Delany
15. Birthplace ..... Maryland

16. Informant ..... Mrs John A Barber Sr
Address ..... 7 W Preston

17. ..... Burial ..... Date thereof ..... July 30-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory ..... Green Mount
Location ..... Balto. Md.
18. Funeral director ..... Henry W. Jenkins Son & Co
Address ..... Orchard & Mcculloh Sts
19. ..... 7/31 ..... 46 ..... Asst. Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... July 27 ..... 19 46, at 12.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Heart Probably	
Myocardial degeneration	
Due to	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE ..... John L. Riley Dep. Md Exam
M. D. or other
Address ..... Brown Hill Md. Date signed 7/27/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

07440

Reg. Dist. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: near Pocomoke City Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Georgia County:

City or town: Augusta Ga

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lizzy Bowels

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife: Joseph Bowels

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): August 21-1910

8. AGE: Years 35 Months 11 Days 1 If less than one day ... hrs. ... min.

9. Birthplace: Elbert Co Georgia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: John Scott

13. Birthplace: S.C.

MOTHER 14. Maiden name: Amanda Myers

15. Birthplace: S.C.

16. Informant: Amanda Myers

Address: Augusta Ga.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) July (day) 31 (year) 1946

Cemetery or crematory: Augusta Ga.

Location: Augusta Ga.

18. Funeral director: Henry Sheldon

Address: Pocomoke City Md.

19. (Date rec'd by registrar) July 30 19 46 Registrar: Anne E. Phillips

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 19 46 at 2 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw h... alive on ... 19 ...

	DURATION
Immediate cause of death: Myocardial degeneration	
Due to: Heart.	unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Dep Md Exam M. D. or other

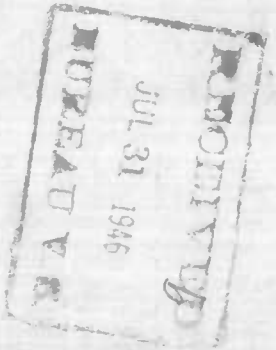
Address: Snow Hill Md Date signed 7/22/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15

PA 12



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

07441

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester
City or town Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Buttingham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	widower

6.(b) Name of husband or wife Annie Buttingham
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1847.

8. AGE: Years 59 | Months — | Days — | If less than one day ... hrs. ... min.

9. Birthplace Berlin Md R.F.D.
(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden name unknown
15. Birthplace

16. Informant Mr. Daniel Tingen
Address Ocean City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/10/46 (month) (day) (year)
Cemetery or crematory Davis
Location Berlin Md R.F.D.

18. Funeral director Emma R. Bunting
Address Berlin Md.

19. 7-10 1946 (Date rec'd by registrar) Helen G. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1946, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946, to June 6 1946
and that I last saw him alive on June 6 1946

Immediate cause of death	DURATION
Chronic Myocarditis	7
Auricular Fibrolation	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. —
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford E. Schutt M. D. or other
Address Berlin Md Date signed 7-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

07442

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9.45-15

1. PLACE OF DEATH:
County: Worcester
City or town: Ocean City —
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? One week
Hospital, institution, or street address where death occurred:
Home Convalescent
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: —
City or town: Balto 28 Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8 South Fremont Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Rose Mary Clark

3.(b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: M

8.(b) Name of husband or wife: Hedley A. Clark
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 9, 1902

8. AGE: Years: 44 Months: Days: 10 If less than one day: hrs. min.

9. Birthplace: Balto Md — (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: John McWilliams
13. Birthplace: Balto —

MOTHER
14. Maiden name: Jane Hart
15. Birthplace: Balto —

16. Informant: H. A. Clark
Address: 8 South Fremont Place — Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/23/46 (month) (day) (year)
Cemetery or crematory:
Location: Baltimore Md
18. Funeral director: Amos A. Burbage
Address: Berlin Md.

19. 7-25 (Date rec'd by registrar) 1946 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1946 at 9.20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1946, to July 19 1946 and that I last saw her alive on July 19 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to: Malignant Hypertension	4 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James Stowell M. D. or other
Address: 715 Fredrick Av Balto 28 Date signed: 7-19

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

07443

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Pocomoke city
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Amanda Coston

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1847

8. AGE: Years 99 | Months | Days | If less than one day hrs. min.

9. Birthplace Pocomoke, Worcester, Md.
(Town, county, and state)

10. Usual occupation Governess

11. Industry or business

FATHER
12. Name Thomas Coston
13. Birthplace Pocomoke, Md

MOTHER
14. Maiden name Mary Aydelotte
15. Birthplace Pocomoke, Md.

16. Informant Mrs. Rose Mary Peters
Address Pocomoke, Md

17. Burial Date thereof July 25, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Gingerstown Cemetery
Location Pocomoke, Md Rural

18. Funeral director Margarette A. Watson
Address Pocomoke city, Md.

19. July 25 1946 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1946 at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1946, to July 23 1946 and that I last saw her alive on July 22 1946

Immediate cause of death	DURATION
Senility & Starvation.	
Due to Advanced Arteriosclerosis.	2 yrs?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Louis S. Llewelyn M.D. M. D. or other
Address Pocomoke City, Md. Date signed 7-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin Md R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 yrs.
Hospital, institution, or street address where death occurred: ✓
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin Md R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Calvin Henry Evans

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Hattie Ellen Evans. 6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Sept 9, 1877

8. AGE: Years: 68 | Months: 10 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Snowhill Md. (Town, county, and state)

10. Usual occupation: Stone Keeper

11. Industry or business: "

FATHER — 12. Name: Capt John Evans. 13. Birthplace: Md.

MOTHER — 14. Maiden name: Margaret E. Dowes. 15. Birthplace: Md.

16. Informant: Hattie E. Evans. Address: Berlin, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 1946 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md.

18. Funeral director: M. Pasha Watson

Address: Selbyville, Del.

19. 7-19 1946 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1946 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to July 17 1946 and that I last saw h.. alive on July 17 1946

Immediate cause of death	DURATION
Carcinoma of Pancreas	4 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L Mucci M.D. M. D. or other

Address: Berlin Md Date signed 7/17/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

07445

Reg. Dist. No. 356

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs

Hospital, institution, or street address where death occurred: 7 Balto. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7 Balto. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Obediah J. Gilden

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

8.(b) Name of husband or wife: Susie J. Gilden

8.(c) If alive, give age: No years

7. Birth date of deceased (mo., day, yr.): June 28, 1862

8. AGE: Years: 84 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Mappsburg, Va. (Town, county, and state)

10. Usual occupation: Waterman

11. Industry or business

MOTHER FATHER

12. Name: Willie Gilden

13. Birthplace: Accomack Co. Va.

MOTHER

14. Maiden name: Margaret Gilden

15. Birthplace: Accomack Co. Va.

16. Informant: Lloyd T. Williams

Address: 7 Balto Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 30, 1946 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Pungoteague, Va.

18. Funeral director: J. D. Johnson, Inc.

Address: Parksley, Va.

19. 7-28 1946 (Date rec'd by registrar) Helen T. Haywood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1946, at 4:50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 June 1946 to 28 July 1946 and that I last saw h- alive on 27 July 1946

	DURATION
Immediate cause of death: Renal Arteriosclerosis	6 mos.
Due to: Arteriosclerosis	Unknown
Due to:	
Other conditions: Senile Dementia	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Nathaniel L. Thomas. M. D. or other

Address: 7th & Philadelphia Ave. Ocean City Md. Date signed: 29 July 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(107) ★ 17446

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: Home - 427 Bank Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 427 Bank St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EDWARD GOLDEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Marie Flora Golden
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): May 27, 1892

8. AGE: Years	Months	Days	If less than one day
54	1	13	...hrs. ...min.

9. Birthplace: Savannah, Georgia
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Abraham Golden
13. Birthplace: Savannah, Georgia

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Marie F. Golden
Address: 427 Bank St., Pocomoke City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 12, 1946 (month) (day) (year)
Cemetery or crematory: Hall's Hill Cemetery
Location: Rural, Pocomoke City, Md.

18. Funeral director: H. Harvey Bradshaw
Address: Pocomoke City, Md.

19. July 12, 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10, 1946, at 4:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3, 1946, to July 10, 1946 and that I last saw him alive on July 7, 1946, 1946.

	DURATION
Immediate cause of death: Bronchial Pneumonia	1 wk.
Due to:	
Due to:	
Other conditions: Gastro Enteritis	1 month

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

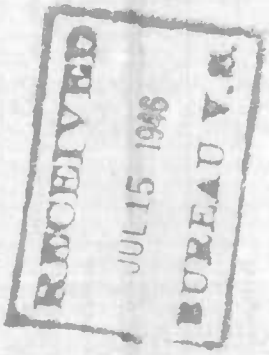
23. SIGNATURE: Louis L. Llewelyn, M.D. M. D. or other
Address: Pocomoke City Date signed: 7-12-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Llewellyn



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

07447

Reg. Dist. No. 3515

1. PLACE OF DEATH:
County Worcester
City or town Berlin md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Berlin Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME Isak Henry Hackett

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a. a.	Married

6.(b) Name of husband or wife Carl Hackett
6.(c) If alive, give age Don't Know years

7. Birth date of deceased (mo., day, yr.) Feb 22. 1892

8. AGE: Years	Months	Days	If less than one day
about 54	4	24	...hrs. ...min.

9. Birthplace Berlin Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Same as above
FATHER 12. Name Isaac Henry
13. Birthplace Berlin Md
MOTHER 14. Maiden name Charlott Smack
15. Birthplace Berlin Md
16. Informant Carl Hackett
Address Berlin Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17 46 (month) (day) (year)
Cemetery or crematory Evergreen
Location Berlin Md
18. Funeral director James D. Stewart
Address Salisbury Md
19. 7-15- 1946 Helen F. Hayward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 46, at 8 P. M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 1946 to July 13 1946
and that I last saw h... alive on July 13 1946

Immediate cause of death Chronic Myocarditis — DURATION

Due to ...

Due to ...

Other conditions ...

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op. ...
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury Injured at work?

23. SIGNATURE Clifford E. Schott M. D. or other
Address Berlin Md Date signed 7/15/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

07448

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH:

County: Worcester

City or town: Showells

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Showells.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Gerald Leon Harmon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 21 1946

8. AGE: Years: 0 Months: 5 Days: — If less than one day: ..... hrs. ..... min.

9. Birthplace: Showells (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: George Harmon

FATHER — 13. Birthplace: Hubert Md

MOTHER — 14. Maiden name: Margaret Guest

MOTHER — 15. Birthplace: Showells Md

16. Informant: Geo. Harmon

Address: Showells

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 26, 1946 (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: Berlin Md

18. Funeral director: Harry A. Walton

Address: Pocomoke City, Md

19. July 27 1946 (Date rec'd by registrar) Hilda Ryan Berger, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1946, at 5.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Premature birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John L. Riley Dep. Med Exam M. D. or other

Address: Berlin Md Date signed 7/26/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

(0744)

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: Worcester.

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Worcester.

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Balto. Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Henry David Hudson.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Maud E. Hudson

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): March 8, 189x

8. AGE: Years: 52 | Months: 4 | Days: 16 | If less than one day: ...hrs. ...min.

9. Birthplace: Bishopville, Wor Co. Md.

(Town, county, and state)

10. Usual occupation: Fisherman

11. Industry or business:

FATHER — 12. Name: David Hudson.

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary Beebe.

15. Birthplace: Virginia

16. Informant: Mrs. Henry Hudson

Address: Ocean City Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: 7/26/46 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: Irma A. Burbage

Address: Berlin Md.

19. 7-26 1946 (Date rec'd by registrar) Helen F. Hayward. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24 1946, at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1946, to July 24 1946 and that I last saw h...alive on July 24 1946

Immediate cause of death	DURATION
Coronary Occlusion	36 hrs.
Due to: Coronary Sclerosis	4 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: Nathaniel L. Thomas M.D. M. D. or other

Address: 501 Balto Ave, Ocean City, Md. Date signed: 25 July 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

07450

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-0)

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: James Timothy Hudson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Phoebe Ann Hudson
6.(c) If alive, give age: —
7. Birth date of deceased (mo., day, yr.): Dec 27 1862

8. AGE:

Years	Months	Days	If less than one day
83	6	29	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: —

FATHER
12. Name: James Hudson
13. Birthplace: Md

MOTHER
14. Maiden name: Mary Bozman
15. Birthplace: Del.

16. Informant: Ray Hudson
Address: Berlin Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: July 28, 1946 (month) (day) (year)
Cemetery or crematory: I.O.O.F.
Location: Bishopsville, Md.

16. Funeral director: M. Pasha Watson
Address: Selbyville Del

19. 7-28 1946 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1946, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1946 to July 26 1946 and that I last saw him alive on July 25 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	24 hrs
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: G E James M. D. or other
Address: Selbyville Del Date signed: 7-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07451

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Rural Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 Years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Worcester
City or town: Rural Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clemon P. Jones

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Mollie Jones
6.(c) If alive, give age: 53 years
7. Birth date of deceased (mo., day, yr.): July 24 1885
8. AGE: Years: 60 Months: 11 Days: 24 If less than one day: hrs. min.
9. Birthplace: Pocomoke, Worcester Md.
(Town, county, and state)
10. Usual occupation: Farming
11. Industry or business:
FATHER 12. Name: William H. Jones
13. Birthplace: Maryland
MOTHER 14. Maiden name: Ellen Watson
15. Birthplace: Maryland
16. Informant: Mrs Mollie Jones
Address: Rural Pocomoke Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21 1946 (month) (day) (year)
Cemetery or crematory: Remson Cemetery
Location: Rural Pocomoke Md.
18. Funeral director: Henry S. Watson
Address: Pocomoke City Md.
19. July 24 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1946 at 5 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1946 to July 19 1946
and that I last saw h[illegible] alive on July 18, 1946 1946
Immediate cause of death: Hypertensive Cardio-Vasc. Dis — DURATION: 5 yrs
Due to:
Due to:
Other conditions: Cerebral Hemorrhage. — 1 yr.
(Include pregnancy within 3 months of death)
Major findings of operations: None.
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis L. Llewellyn, M.D.
M. D. or other
Address: Pocomoke City Date signed 7-22-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

07452

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, institution, or street address where death occurred:
Home - 4th Street, No 206
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 206 4th Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
CLARA SHREVES MATTHEWS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or ~~wife~~: Sylvanious W. Matthews
6.(c) If alive, give age 89 ~~87~~ years

7. Birth date of deceased (mo., day, yr.): August 6, 1865

8. AGE: Years	Months	Days	If less than one day
80	11	4	....hrs. ....min.

9. Birthplace: Accomac County, Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William H. Shreves
13. Birthplace: Accomac County, Virginia

MOTHER
14. Maiden name: Caroline (?)
15. Birthplace: Accomac County, Virginia

16. Informant: Norman Matthews
Address: Pocomoke City, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12, 1946 (month) (day) (year)
Cemetery or crematory: Episcopal Cemetery
Location: 4th St - Pocomoke City, Md.

18. Funeral director: H. Harvey Bradshaw
Address: Pocomoke City, Md.

19. July 12, 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1946, at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~1943~~, to July 10 1946; and that I last saw ~~her~~ alive on July 9 1946

Immediate cause of death	DURATION
Pulmonary T.B.	20 yrs
T.B. of Intestines	3 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: [illegible] Date signed 7-12-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

Dr. Griffith

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

07453

Reg. Diat. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Ocean City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mo.
Hospital, Institution, or street address where death occurred: Balto. Ave., 6th St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County: Princess Anne
City or town: Norf. Lk
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie Lee Megginson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~Female~~	White	Widowed

6.(b) Name of husband or wife: Benjamin J. Megginson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JAN. 5, 1875

8. AGE: Years	Months	Days	If less than one day
71	6	9	hrs. min.

9. Birthplace: Norfolk, Virginia (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Dennis Capps
13. Birthplace: Va.

MOTHER
14. Maiden name: Jakey Duffy
15. Birthplace: Va.

16. Informant: Mrs. W. G. Wyman
Address: Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/18/46 (month) (day) (year)
Cemetery or crematory: Elmwood Cem.
Location: Norfolk Va
18. Funeral director: Annie A. Burbage
Address: Berlin Md.

19. 7-16 1946 Helen F. Hayward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1946, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1946, to July 14 1946
and that I last saw h.. alive on 14 July 1946

Immediate cause of death	DURATION
Coronary Occlusion	10 Minutes
Due to: Coronary Sclerosis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none performed.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Nathaniel R. Thomas M.D. M. D. or other
Address: 501 Baltimore Ocean City Date signed: 15 July 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

07454

Reg. Dist. No. 353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Worcester
City or town: near Selbyville Del Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: near Selbyville Del Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Louise Mumford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 10, 1942

8. AGE:

Years	Months	Days	If less than one day
4	6	1	..... hrs. ..... min.

9. Birthplace: Bishop, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Alexander Mumford
13. Birthplace: Bishop Md.

MOTHER
14. Maiden name: Doris Laws
15. Birthplace: Selbyville, Del.

16. Informant: Alexander Mumford
Address: Bishop, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14, 1946 (month) (day) (year)
Cemetery or crematory: Sarah Dukes Cemetery
Location: near Bishop Md.

18. Funeral director: Henry T. Watson
Address: Pocomoke City, Md.

19. 7/12/1946 (Date rec'd by registrar) 19 ..... Hilda Ryan Berger Registrar

MEDICAL CERTIFICATION (C.115)

20. DATE OF DEATH: July 11 1946 at 7.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractures Skull	—
Due to: Auto accident	—
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of July 11 '46
Where did injury occur? near Selbyville Sussex Co Del
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway # 113
Means of injury: Struck by Auto Injured at work? No

23. SIGNATURE: John L. Riley D.P.S. Med Exam
M. D. or other
Address: Snow Hill Md Date signed 7/11/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Accomack
City or town: New Church
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME George E. Parks

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Laura Parks
8.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Dec 9-1860

8. AGE:

Years	Months	Days	If less than one day
85	7	21	hrs. min.

9. Birthplace: Gilford Accomac Virginia
(Town, county, and state)
10. Usual occupation: Farming
11. Industry or business

FATHER
12. Name: Charles Parks
13. Birthplace: Virginia

MOTHER
14. Maiden name: Margaret Lewis
15. Birthplace: Virginia

16. Informant: Mr Asa T Taylor
Address: Pocomoke City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 1-1946 (month) (day) (year)
Cemetery or crematory: Nelson Cemetery
Location: Rural Pocomoke Md
18. Funeral director: Henry G. Watson
Address: Pocomoke City Md.
19. July 31 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30 1946, at 9 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 1946, to Dec 30 1946
and that I last saw h— alive on Dec 28 1946
Immediate cause of death: Myocardial Degeneration

	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: C. E. Gutchen M.D. M. D. or other
Address: — Date signed: 7-31-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

* 17456

Reg. Dist. No. 355

1. PLACE OF DEATH:

County WORCESTER

City or town BERLIN

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WORCESTER

City or town BERLIN

(If outside city or town limits, write RURAL and give nearest town)

Street No. POWELLTON AVE

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ANNIE L. PORTER.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	white	married

6.(b) Name of husband or wife Fletcher Porter

8.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) OCT. 16, 1884

8. AGE: Years	Months	Days	If less than one day
61	8	29	....hrs. ....min.

8. Birthplace Berlin Wor Co Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Smack

13. Birthplace Md.

MOTHER 14. Maiden name Lavinia Smith

15. Birthplace Md.

16. Informant Mrs. Fletcher Porter

Address Berlin Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/17/46 (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md

18. Funeral director Emma B. Burbage

Address Berlin Md.

19. 7-17-46 Helen F. Hayward Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15th 1946, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938 19[redacted] to July 15 1946

and that I last saw h.. alive on July 15 1946

Immediate cause of death Carcinoma of Liver — DURATION 9 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L Shuck M.D.

M. D. or other

Address Berlin Md Date signed 7/16/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 N. Coll

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

07457

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke City Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke City Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: George Price

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Ella Price
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 10 - 1865

8. AGE: Years: 81 | Months: 1 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pocomoke City Worcester Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: George Price
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rose Elen
15. Birthplace: Maryland

16. Informant: Henry Wray Cottingham
Address: Pocomoke City, Md Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21/46 (month) (day) (year)
Cemetery or crematory: Baptist
Location: Snow Hill, Md

18. Funeral director: Hearne & Dennis
Address: Snow Hill, Md

19. July 21, 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18, 1946, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8th, 1946 to July 17, 1946 and that I last saw h... alive on July 17th, 1946

	DURATION
Immediate cause of death: Asthenia Apoplexy	2 weeks
Due to:	
Due to: Debility,	Years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. E. Peters M.D.
M. D. or other
Address: Pocomoke City Md Date signed 7/19/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

17458

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 710 N. Lakewood ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: [illegible] ★ ✓

3. (a) FULL NAME: John J. Samaradgis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Victoria Joanna Samaradgis

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): April 19, 1912

8. AGE:

Years	Months	Days	If less than one day
34	3	10	..... hrs. ..... min.

9. Birthplace: Michigan (Town, county, and state)

10. Usual occupation: Merchant Seaman.

11. Industry or business:

FATHER

12. Name: Matthew Samaradgis

13. Birthplace: Michigan

MOTHER

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Mrs. John J. Samaradgis

Address: Baltimore Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/2/46 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore Md

18. Funeral director: Philip Herring Sons.

Address: 2024 Orleans St Balto. Md

19. 7-31 1946 (Date rec'd by registrar) Helen L. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 1946, at 1.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Drowning	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of July 29 46

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Dep. Md Exam M. D. or other

Address: Snow Hill Md Date signed 7/29/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

17459

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Rural Pocomoke City Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Weeks
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Florida County: Jackson
City or town: Sneads
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: James Sherman

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Beaulah Sherman
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Dec. 25-1913

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
32	6	20		

9. Birthplace: Sneads Jackson Florida (Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business: —

FATHER
12. Name: Robert Sherman
13. Birthplace: Georgia

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Beaulah Sherman
Address: Pokoke Florida

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21 1946 (month) (day) (year)
Cemetery or crematory: Millville Cemetery
Location: Millville Florida

18. Funeral director: Henry T. Watson
Address: Pocomoke City Md

19. July 16 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1946 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Pulmonary hemorrhage	15 Min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Thos L. Riley Dep. Med Exam M. D. or other
Address: Snow Hill Md Date signed 7/15/46

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

(17460)

Reg. Dist. No. 355

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Peter L. Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Annie C. Taylor
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Aug. 4 1875

8. AGE: Years: 70 | Months: 11 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Berlin, Worcester, Md.
(Town, county, and state)

10. Usual occupation: CARPENTER

11. Industry or business

FATHER 12. Name: Joseph H. Taylor
13. Birthplace: Berlin

MOTHER 14. Maiden name: Cordelia Harmon
15. Birthplace: Berlin

16. Informant: Mrs. PETER L. TAYLOR
Address: BERLIN

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7/13/46 (month) (day) (year)
Cemetery or crematory: EVERGREEN
Location: BERLIN MD

18. Funeral director: ANNA A. BURBAGE
Address: BERLIN MD

19. 7-11 1946 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 — 1946, at 8.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 1945, to July 11 1946
and that I last saw alive on July 11 1946

Immediate cause of death	DURATION
Acute Dilated	
Due to heart fran	
Due to Chronic Brights	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Law MD
M. D. or other
Address: Berlin Md Date signed 7-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Near Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: —
Hospital, institution, or street address where death occurred:
How long in hospital or institution?: —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: accomac Va
City or town: New accomac Va.
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ada Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col'd	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 10, 1924

8. AGE:

Years	Months	Days	If less than one day
21	11	26	hrs. min.

9. Birthplace: Sherman, Randolph, Ga.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:

FATHER
12. Name: Ernest Thompson
13. Birthplace: Georgia

MOTHER
14. Maiden name: Eva Perdue
15. Birthplace: Georgia

16. Informant: Earl Thompson
Address: Meigs, Georgia

17. Burial: Pelham
(Burial, cremation, or removal. Which?) Date thereof: July 13 1946 (month) (day) (year)
Cemetery or crematory: Pelham
Location: Pelham, Georgia

18. Funeral director: Henry H. Watson
Address: Pocomoke city, Md.

19. July 10, 1946 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 1946, at 6.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Fractured skull	
(b) Broken neck	
Due to: Being thrown from a Moving Truck	
Due to: Stopping Suddenly	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: July 6 46
Where did injury occur?: Near Pocomoke City Worc Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Thrown from Truck Injured at work? —

23. SIGNATURE: John L. Riley Dep. Med Exam
M. D. or other
Address: Snow Hill Md Date signed: 7/6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15